vitalcare of SAN ANGELO

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# SIMPONI ARIA (GOLIMUMAB)
# INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis
- ☐ TB Test Results (Yearly Screening)
- ☐ **Hepatitis B Protocol:** Hep B surface antigen and Hep B Core AB total required.

| | |
|---|---|
| **Patient Name:** | **DOB:** |
| **Allergies:** | **Patient Phone:** |

**Diagnosis:** ☐ Rheumatoid Arthritis (ICD-10_____)
☐ Psoriatic Arthritis (ICD-10_____)
☐ Ankylosing Spondylitis (ICD-10_____)
☐ Other:_____ (ICD-10_____)

**J Code: J1602**

## SIMPONI ARIA ORDERS

Initial dose: ☐ 2mg/kg infused over 30 mins at weeks 0, 4 and then every 8 Patient Weight: _____kg

Maintenance dose: ☐ Every 8 weeks

*Date of last ☐ Remicade ☐ Orencia ☐ Humira ☐ Cimzia ☐ Enbrel
☐ Actemra ☐ Kineret ☐ Simponi ARIA dose:_____ Date:_____

**Additional Instructions:**

| | | |
|---|---|---|
| **Physician Name:** | **Phone:** | **Fax:** |
| ****Physician Signature:** | **Date:** | |